



Navigating Prior Authorization: A Provider's Guide to Success: Prior Authorization

2025 IHCP Works Annual Seminar

Presented by Kristy Huse, Provider Account Manager (Medical)

Optum Behavioral Health: Paulette Means and Kristin Johnson

UnitedHealthcare Vision: Elizabeth Faceson

UnitedHealthcare Dental: Kelly Davis

**United
Healthcare**

Agenda

1. Admission Notification
2. Obtaining Prior Authorization for Medical:
 - Requirements
 - Chat Support
 - Education and Training
 - Point of Care Assist
3. Behavioral Health
4. Dental
5. Vision



Our Service Lines

- UnitedHealthcare
- Optum® Behavioral Health
- March® Vision Care
- UnitedHealthcare Dental





Admission Notification

Admission Notification

Admission notification: General acute care facilities should notify UHC of the inpatient admission within 48 hours after admission. Nursing facilities should follow notification and Level of Care requirements for admission as outlined in the [IHCP Long-Term Care Provider Reference Module](#)

Notify UnitedHealthcare of an Admission:

- Electronic Data Interchange (EDI) 278N Transaction (easiest and most preferred method)
- Online via the Prior Authorization and Admission Notification (PAAN) tool: [UnitedHealthcare Provider Portal resources | UHCprovider.com](#)
- Via phone at 877-610-9785 8 a.m. – 8 p.m. ET Monday – Friday
- Via Fax at 844-897-6514: [Prior Authorization and Notification | UnitedHealthcare Community Plan of Indiana | UHCprovider.com](#)

Note: Non-member specific information is available without logging in, this includes Crosswalks, Administration Guides, Peer to Peer Request, Etc.

Member specific information is available after log into [UnitedHealthcare Community Plan of Indiana Homepage | UHCprovider.com](#)



Admission Notification – EDI 278N Transaction

- Use the Hospital Admission Notification (278N) transaction to exchange admission notification data between an inpatient facility and UHC in a standard format
- It can be transmitted directly to UnitedHealthcare or through a clearinghouse in either batch or real-time format
- To get started, contact your vendor or clearinghouse. Most clearinghouses already send 278N transactions to UnitedHealthcare and can work with you to submit notifications in the appropriate format
- For additional information regarding the EDI 278N Transaction please visit our website at:

[EDI 278N: Hospital Admission Notification | UHCprovider.com](https://uhcprovider.com/EDI278N)



Prior Authorization Requirements for Indiana Hoosier Care Connect & Indiana PathWays for Aging

Prior authorization: Requesting medical necessity review and approval before rendering a service is required by UnitedHealthcare policy for some services. It's required under the direction of the UnitedHealthcare Health Services Department and is an essential part for our managed care organization.

Advance notification is required to give UnitedHealthcare timely communication of services so we can do a prospective, concurrent, and retrospective care review.

*Prior authorization is ***not required*** for emergency or urgent care





Medical

Medical: Check Prior Authorization Requirements

Providers can check prior authorization requirements at:

[UnitedHealthcare Community Plan of Indiana Homepage](#)

Home > Health Plans by State > Indiana health plans > UnitedHealthcare Community Plan of Indiana Homepage

UnitedHealthcare Community Plan of Indiana Homepage

Bulletins and Newsletters | UnitedHealthcare Community Plan of Indiana

Care Provider Manuals

Claims and Payments | UnitedHealthcare Community Plan of Indiana

Eligibility and Benefits

How to Join the UnitedHealthcare network | Indiana

Pharmacy Resources and Physician Administered Drugs | UnitedHealthcare Community Plan of Indiana

Policies and Clinical Guidelines | UnitedHealthcare Community Plan of Indiana

Prior Authorization and Notification | UnitedHealthcare Community Plan of Indiana

Provider Forms and References | UnitedHealthcare Community Plan of Indiana

UnitedHealthcare Community Plan of Indiana Homepage

Last update: May 14, 2025

We know you don't have time to spare, so we put all the UnitedHealthcare Community Plan resources you need in one place. Use the navigation on the left to quickly find what you're looking for. Be sure to check back frequently for updates.

Indiana PathWays for Aging continuity of care period

UnitedHealthcare (UHC) Pathways will honor existing A&D waiver service authorizations for up to 90 days from the date of enrollment. Members currently receiving A&D waiver services can continue receiving those same services under the UHC Pathways program. Please continue to provide services as we work to send authorization notices to you for those you serve. If you have any questions, please email IN_providerservices@uhc.com.

Prior Authorization and Notification Resources

Learn more

Current Policies and Clinical Guidelines

Learn more

Provider Administrative Manual and Guides

Learn more

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Medical: Check Prior Authorization Requirements (cont.)

[Prior authorization requirements for Indiana Hoosier Care Connect](#)

[Prior authorization requirements for Indiana Pathways for Aging](#)

Prior Authorization and Notification | UnitedHealthcare Community Plan of Indiana

Last update: May 29, 2025

We have online tools and resources to help you manage your practice's notification and prior authorization requests.

To submit and manage your prior authorizations, please sign in to the UnitedHealthcare Provider Portal. Additional information on prior authorizations is available on uhcprovider.com/priorauth.

[Sign in](#)

Current Prior Authorization Plan Requirements

- [UnitedHealthcare Community Plan Prior Authorization Indiana Hoosier Care Connect - Effective July 1, 2025](#) [↗](#)
- [UnitedHealthcare Community Plan Prior Authorization Indiana Pathways for Aging - Effective July 1, 2025](#) [↗](#)



Medical: Check Prior Authorization Requirements (cont.)

[Prior authorization requirements for Indiana Pathways for Aging effective Aug. 1, 2025](#)

Note: Use Ctrl-F to search for a specific CPT or HCPCS code:



General information

This list contains prior authorization requirements for participating UnitedHealthcare Community Plan of Indiana health care professionals providing inpatient and outpatient services. Please submit your request in 1 of the following ways:

- **Online:** Use the Prior Authorization and Notification tool on the UnitedHealthcare Provider Portal. To get started, go to [UHCprovider.com](#) and click Sign In in the top-right corner to log in using your One Healthcare ID and password. Then, select the Prior Authorization and Notification tab on your dashboard. If you don't have a One Healthcare ID, visit [UHCprovider.com/access](#).
- **Phone:** Call 877-610-9785

Prior authorization is not required for emergency or urgent care. Out-of-network requests must be made by network care provider.

Procedures and services	Additional information	CPT® or HCPCS codes and how to obtain prior authorization			
Bariatric	Prior authorization is required. There is a Center of Excellence requirement for coverage of bariatric surgery and services. In certain situations, bariatric surgery and other obesity-related services aren't covered by some benefit plans.	43644	43645	43659	43770
		43771	43772	43773	43774
		43775	43842	43843	43845
		43846	43847	43848	44799
		44705			



Medical: Check Prior Authorization Requirements (Provider Portal)

Use the Prior Authorization and Notification tool via our UnitedHealthcare Provider Portal to:

[UnitedHealthcare Provider Portal resources | UHCprovider.com](https://UHCprovider.com)

- Determine if notification or prior authorization is required
- Complete the notification or prior authorization process
- Upload medical notes or attachments
- Check request status and advance notification/lists



Medical: Check Prior Authorization Requirements (Portal Sign in)

1. Sign in to the UnitedHealthcare Provider Portal, from UHCprovider.com
2. Select the “Prior Authorizations and Notifications” tab
3. Select “Check by code”


The screenshot displays the UnitedHealthcare Provider Portal interface. At the top, the UnitedHealthcare logo is on the left, and navigation links for Training & Support, Practice Management, and TrackIt (99+) are on the right. A search bar is located below the logo. The main navigation bar includes tabs for Eligibility, Claims & Payments, Referrals, Prior Authorizations (highlighted with an orange box), Clinical & Pharmacy, Documents & Reporting, and Additional Tools. Below the navigation bar, a 'Welcome!' message is followed by a reminder to verify payer and provider information. The left sidebar contains a list of menu items: Action Required (99+), Eligibility, Claims & Payments, Referrals, Prior Authorizations & Notifications (highlighted with an orange box and an arrow pointing to the 'Check by code' option), Documents & Reporting, and UnitedHealthcare Updates. The main content area is titled 'Create new or view existing prior authorization submission' and includes buttons for 'Create a new request' and 'View existing submissions'. Below these, there are two options: 'Check if prior authorization is required for a medical service' and 'Check by member'. The 'Check by code' option is circled in orange and has an arrow pointing to it from the 'Prior Authorizations & Notifications' menu item. The 'Check by code' option includes a sub-link 'Check by procedure code(s), product type, state and diagnosis. Applies to medical services only.' The 'Check by member' option includes a sub-link 'Check by member, procedure code(s) and case details to generate a reference number (Decision ID). Applies to medical services only.'




Medical: Check Prior Authorization Requirements (Portal entries)

1. Select the product type and state
2. Enter the diagnosis code (optional)
3. Enter the procedure code(s)


Product type & state


 **Medical services only**
Your search is not a request for prior authorization and is not a notification to UnitedHealthcare. Prior authorization requirements vary by benefit plan and the provider's participation status. Your search does not guarantee coverage. Coverage determinations are based on the member's benefit plan and eligibility for benefits, in addition to other criteria.


For **Home and Community Based Services**, please call the number on the back of the member's ID card.

Product type  *

State *

Medicald 

Indiana 

[Looking for information on behavioral health?](#) 

Diagnosis code details

0 of 1 **DIAGNOSIS CODES ADDED TO INQUIRY**. You can add up to 1 **OPTIONAL** diagnosis code. It will be paired with each selected procedure code and used to determine the results.

Click on the star icon to favorite a code once it is added. Once favorited, you can quickly reference it and add it from your favorites in future inquiries.

Add a new diagnosis code

You can add 1 optional diagnosis code

Not sure which diagnosis code to use? [Look up code](#)

You are able to select up to **5 procedure codes** and **1 optional diagnosis code**.

[Cancel](#) [Continue](#)



Medical: Create New Prior Authorization

1. Sign in to the UnitedHealthcare Provider Portal, from UHCprovider.com
2. Select the “Prior Authorizations and Notifications” tab
3. Select “Create a new request”


The screenshot displays the UnitedHealthcare Provider Portal interface. At the top, the UnitedHealthcare logo is on the left, and navigation links for Training & Support, Practice Management, and TrackIt (99+) are on the right. A search bar and dropdown menus for Payer (87726 - UnitedHealthcare) and Provider are also present. Below the header is a dark blue navigation bar with tabs: Eligibility, Claims & Payments, Referrals, Prior Authorizations, Clinical & Pharmacy, Documents & Reporting, and Additional Tools. The main content area has a 'Welcome!' message and a reminder to verify payer and provider information. On the left sidebar, the 'Prior Authorizations & Notifications' tab is highlighted with an orange box. In the main content area, under the heading 'Create new or view existing prior authorization submission', the 'Create a new request' button is highlighted with an orange circle. Other options include 'View existing submissions' and 'Check if prior authorization is required for a medical service'. The right sidebar contains 'PAAN Resources' and 'Quick Links & Tools'.






Medical: Creating a New Prior Authorization (entries)


1. Select the product type and state
2. Enter the diagnosis code (optional)
3. Enter the procedure code(s)

Product type & state

 **Medical services only**
Your search is not a request for prior authorization and is not a notification to UnitedHealthcare. Prior authorization requirements vary by benefit plan and the provider's participation status. Your search does not guarantee coverage. Coverage determinations are based on the member's benefit plan and eligibility for benefits, in addition to other criteria.
For **Home and Community Based Services**, please call the number on the back of the member's ID card.

Product type  *****
Commercial 

State *****
Alabama 

[Looking for information on behavioral health?](#) 

Diagnosis code details

0 of 1 DIAGNOSIS CODES ADDED TO INQUIRY. You can add up to 1 OPTIONAL diagnosis code. It will be paired with each selected procedure code and used to determine the results.

Add a new diagnosis code

You can add 1 optional diagnosis code

Not sure which diagnosis code to use? [Look up code](#)

Procedure code details

0 of 5 PROCEDURE CODES ADDED TO INQUIRY. You can add up to 5 procedure codes. **Medical services only.**

Search by code, or code description to determine if prior authorization is required based on the member's line of business (Commercial, Medicare, Medicaid) and state in which their insurance is issued.

Add a new procedure code

You can add up to 5 procedure codes



Medical: Prior Authorization Submission Tips

- If the rendering provider you are trying to select is not an option, select another provider within the group for the authorization
- Use the “Find Facility” search tool to locate the facility where the service will be performed
- Use the asterisk symbol (*) to help you find the results you are looking for. Typing less with a wildcard will help return the results you are looking for
- UnitedHealthcare Community Plan uses InterQual® for medical care determinations
- You can access our UnitedHealthcare Community Plan of Indiana Clinical Guidelines: [Clinical Practice Guidelines \(National\) - UnitedHealthcare Community Plan](#)



Medical: Tips to Avoid Prior Authorization Denials

- Be thorough and complete all the requested documentation
- Ensure that you are answering all authorization questions
- All prior authorizations must have the following:
 - Patient name and Medical ID number
 - Ordering care provider or health care professional name and TIN/NPI
 - Rendering care provider or health care professional and TIN/NPI
 - ICD-10 Diagnosis Codes
 - Anticipated date(s) of service
 - Primary and secondary procedure code(s) and number of units or visits, etc., when applicable
 - Service setting
 - Facility name and TIN/NPI, when applicable



Medical: Prior Authorization Requests Must Be Timely

- Problem: UHC does not receive ***routine*** prior authorization requests for scheduled services well in advance of the service date.
- Solution: Submit your prior authorization request online, via the PAAN tool on the Provider Portal as soon as the service/procedure is scheduled.
- For example, if a surgery is scheduled 2 months in advance, submit the prior authorization as soon as possible after scheduling. This will result in a timely determination well in advance of the scheduled service date.
- UnitedHealthcare generally requires a decision on a non-urgent prior authorization request within 7 to 15 days (and up to 14 calendar days), while an urgent request is decided within 72 hours of receiving the request. These timelines are for pre-service requests and are outlined in the provider manual



Medical: Avoiding Adverse Determinations and/or Peer-to-Peer Reviews

- Problem: UHC often does not receive complete clinical information with the authorization request to make a medical necessity determination
- Solution: Following the suggestions below will result in less adverse determinations, more timely decision turnaround times, a reduction in the need for peer-to-peer reviews, and/or requests for additional clinical information:
 - Submitting prior authorizations online via the PAAN tool
 - Submission of all required clinical information
 - Completion of all fields within the online request leaving no fields blank and avoiding answering with “N/A”



Medical: How to Appeal an Adverse Decision

- If a provider's Prior Authorization request is denied, they may request a peer-to-peer review by calling 1-800-955-7615 from 9 a.m.– 6 p.m. ET, Monday–Friday
- If provider disagrees with the peer-to-peer decision, they may file an appeal. Once an appeal is filed a provider cannot go back and request a peer-to-peer review. Please note that even if a peer-to-peer review is not completed, a provider may still file an appeal. All steps in the process are outlined in the decision letter sent by the authorization team
- If it is taking longer than the state mandated turnaround time to receive a decision, escalate to the Provider Account Management team by going to ([UnitedHealthcare Community Plan of Indiana Homepage](#) “Contact Us” and reviewing Medical Provider Advocates by Counties Served (For Medical Providers))



Medical: Peer-to-Peer Process

- Peer-to-peer reviews can be requested 7 (HCC), or 15 (PathWays) business days from verbal notification of an adverse determination (this includes Inpatient Level of Care denials)
- A peer-to-peer review should be requested by facilities when Inpatient Level of Care is denied
- A peer-to-peer review can also be requested if a prior authorization for a scheduled procedure is denied
- A prior authorization request that does not meet coverage criteria or lacks sufficient information upon submission may “pend” for a peer-to-peer review



Medical: Prior Authorization Decision Turnaround Times

[UnitedHealthcare Community Plan of Indiana Care Provider Manual - Indiana PathWays for Aging Provider Manual \(uhcprovider.com\)](#)

Type of request	Decision Turnaround Times	Practitioner notification of approval	Written practitioner/member notification of denial
Non-urgent pre-service	Within 5 business days or 7 calendar days (whichever comes first) of receipt of medical record information required but no longer than 14 calendar days from receipt	Within 24 hours of the decision	Within 2 business days of the decision
Urgent/expedited pre-service	Within 48 hours of request receipt	Within 48 hours of the request	Within 48 hours of the request (HCBS notification within 24 hours)
Concurrent review	Within 48 hours	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within 2 business days
Retrospective review	Within 30 calendar days of receiving all pertinent clinical information	Within 30 calendar days of determination	Within 30 calendar days of determination; at least 10 business days before the date of action



Medical: Clinical Policies – Example

Over the next few slides, we are going to review clinical policies and will be using Bariatric Surgery as the example, clinical policies will apply to all medical services.

Indiana Medicaid Bariatric Surgery Medical Policy

[Surgical Services Provider Reference Module](#)

Bariatric Surgery and Revisions

Bariatric surgery is recognized as medically necessary when used for the treatment of morbid obesity. Providers must report ICD-10 diagnosis code E66.01 – *Morbid obesity* with the most specific procedure code available that represents the procedure performed.



Medical: Be Familiar with Our Clinical Policies

Providers can view our clinical policies [here](#)

Home > Health Plans by State > Indiana health plans > UnitedHealthcare Community Plan of Indiana Homepage
> Policies and Clinical Guidelines | UnitedHealthcare Community Plan of Indiana

Policies and Clinical Guidelines |
UnitedHealthcare Community Plan of
Indiana

Reimbursement Policies for
Community Plan of Indiana

Medical and Drug Policies for
Community Plan of Indiana

Policies and Clinical Guidelines

Last update: February 5, 2024

Reimbursement Policies

View the current UnitedHealthcare Community Plan Reimbursement Policies.

[View Current Reimbursement Policies](#)

Clinical Guidelines

We have compiled a list of evidence-based clinical guidelines and where they can be found for our quality and health management programs.

We respect the expertise of the physicians and other health care professionals in our network and appreciate your help as we work together to offer our members better quality, better health outcomes and better cost.

If you have questions, please contact your Physician Advocate or call the number on the back of the member's ID card.

[View Clinical Practice Guidelines](#)



Medical: Be Familiar with Other Clinical Policies

Cont.

Bariatric surgery

- UHC follows in this order:
 - State and federal medical policy regulations
 - UnitedHealthcare medical policy
 - InterQual medical policy



Medical: Clinical Policies

UHC Medicaid Bariatric Surgery Medical Policy

Bariatric Surgery – Community Plan Medical Policy



UnitedHealthcare® Community Plan
Medical Policy

Bariatric Surgery

Policy Number: CS007.W
Effective Date: April 1, 2025

 [Instructions for Use](#)

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Related Community Plan Policies

- [Minimally Invasive Procedures for Gastric and Esophageal Diseases](#)
- [Obstructive and Central Sleep Apnea Treatment](#)
- [Robotic-Assisted Surgery Policy, Professional](#)

Commercial Policy

- [Bariatric Surgery](#)



Medical: Process to Dispute a Prior Authorization Decision and File Appeal

When there is an initial adverse determination of a prior authorization request:

- Provider's next available step is a peer-to-peer review
- If the denial is upheld, the provider can then appeal the determination
- If no peer-to-peer was requested and an appeal was filed, then the provider is no longer eligible for a peer-to-peer review
- Provider will receive a letter of adverse determination; it will detail steps needed to request a peer-to-peer review and/or an appeal



Medical: External Review

- When requested, an external review of a prior authorization can be performed by an independent reviewer organization (IRO)
- Member must file the external review request within 120 calendar days from receiving the appeal decision
- We utilize the state's recommended list of IROs to conduct the external review
- A decision by the IRO is made within 72 hours if expedited, or within 15 business days for standard appeals
- The decision by the IRO is binding and not disputable by UnitedHealthcare



Medical: State Fair Hearings

- The Indiana Family Social Services Administration maintains a fair hearing process which allows members the opportunity to appeal the contractor's decisions. Members can find out how to submit a request for a state fair hearing [here](#)
- Members must first exhaust all grievance and appeal options with UnitedHealthcare
- Members may file for a state fair hearing within 120 calendar days from the adverse determination notice of the final appeal
- The member and member's representative as well as a representative of UnitedHealthcare attends the hearing
- If the member is dissatisfied with the outcome of the hearing, they may request an agency review within 10 days of the administrative law judge's decision



Medical: Retroactive Authorizations and Medical Claim Review

- Retroactive authorization:
 - Retroactive authorizations will be issued when the “No authorization” denial was due to eligibility issues
- Medical claim review (MCR) performs medical necessity reviews on denied claims when a prior authorization/admission notification was not obtained or if inpatient level of care was denied during the member’s inpatient stay
 - Example: Provider obtains authorization for a particular code, then upon entering the surgical site, the provider must perform an additional or different service than what was originally approved
 - The claim would be filed, denied, and then reviewed by the medical claim review team upon submission of a Claim Reconsideration with documentation that supports medical necessity attached
 - MCR would only be used in scenarios in which PA could not be obtained due to retro-eligibility





Chat Support

United
Healthcare

Payer

87726 - UnitedHealthcare

Provider

Notification/prior authorization case: A226

Flag case



A decision has already been rendered on this case, though some updates are permitted as indicated in the enabled fields below. To request an additional service for this member, please submit a new notification/prior authorization request for the member.

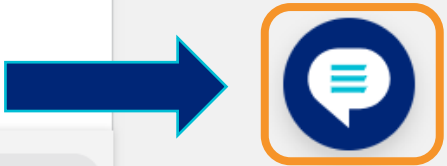
Case details

Notification/prior authorization number	Case status	Case status reason	Primary care physician
A226	Closed	Case was managed and is now complete	—
Advance notify date/time			
01/24/2024, 2:14 PM CST			

Coverage status

Test code	Test code review type	Overall coverage status	Decision date
94372	Unproven	Not Covered/Not Approved	01/29/2024

Procedure code associated with the test





Payer

87726 - UnitedHealthcare

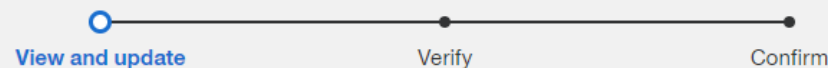
Provider


[Eligibility](#)
[Claims & Payments](#)
[Referrals](#)
[Prior Authorizations](#)
[Clinical & Pharmacy](#)
[Documents & Reporting](#)
[Additional Tools](#)
[Admin](#) / [Home](#) / [Prior authorizations & notifications](#)

Print

Notification/prior authorization case: A226

Flag case



! A decision has already been rendered on this case, though some updates are permitted as indicated in the enabled fields below. To request an service for this member, please submit a new notification/prior authorization request for the member.

Case details

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A226	Closed	Case was managed and is now complete	—
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Coverage status

Test code	Test code review type	Overall coverage status	Decision date
94372	Unproven	Not Covered/Not Approved	01/29/2024

Procedure code associated with the test

[Back to top](#)
[Cancel](#)
[Request case cancellation](#)

Type your message

34



Message us

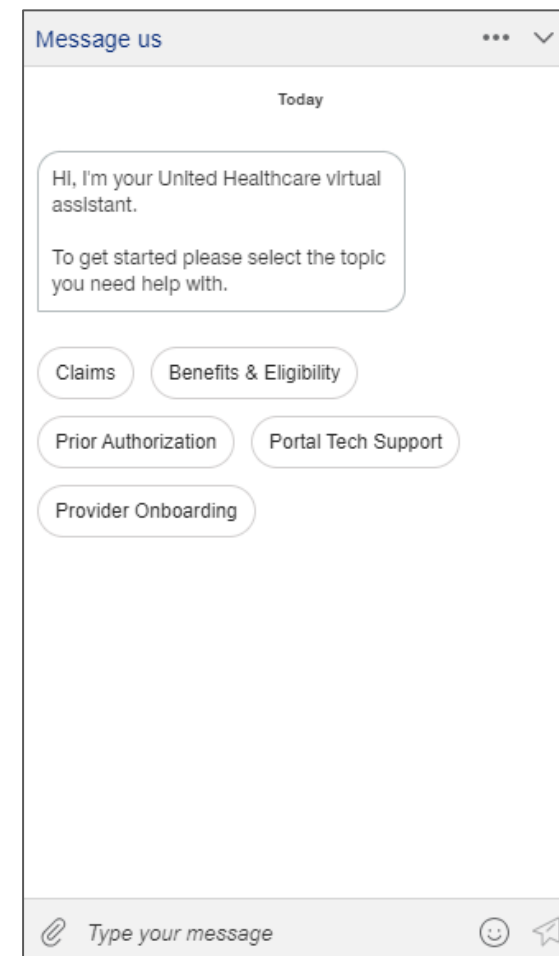
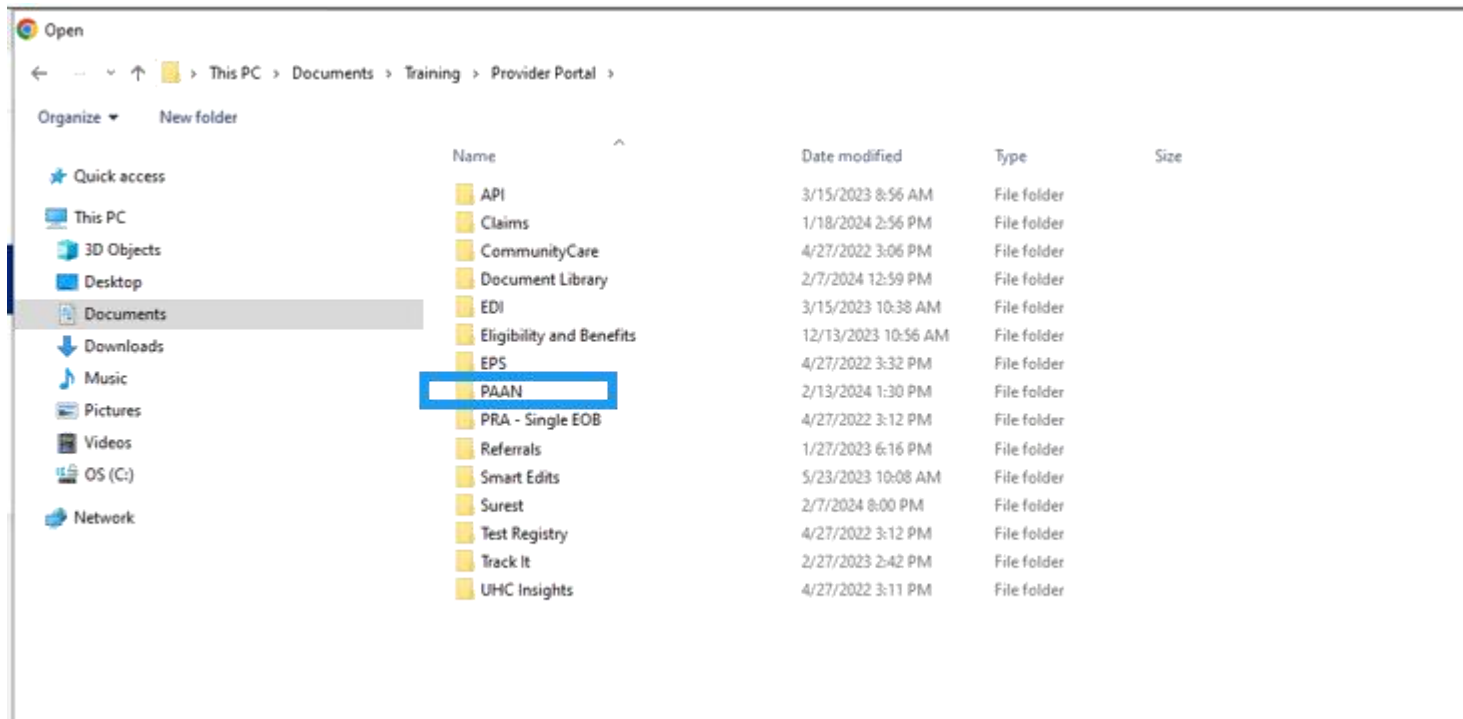
Today

Hi, I'm your United Healthcare virtual assistant.

To get started please select the topic you need help with.

[Claims](#)
[Benefits & Eligibility](#)
[Prior Authorization](#)
[Portal Tech Support](#)
[Provider Onboarding](#)
[Feedback](#)

Attach a Document



Notification/prior authorization case: A226

[Flag case](#)


! A decision has already been rendered on this case, though some updates are permitted as indicated in the enabled fields below. To request an service for this member, please submit a new notification/prior authorization request for the member.

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94372	Unproven	Not Covered/Not Approved	01/29/2024

Procedure code associated with the test

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[End conversation](#)

LIVEPERSON

[Claims](#)
[Benefits & Eligibility](#)
[Prior Authorization](#)
[Portal Tech Support](#)
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[Feedback](#)



Education and Training

Resources for the Provider Portal

A series of three thick, dark blue wavy lines that flow from the left side of the page, under the main text, and curve upwards towards the right side.

United
Healthcare

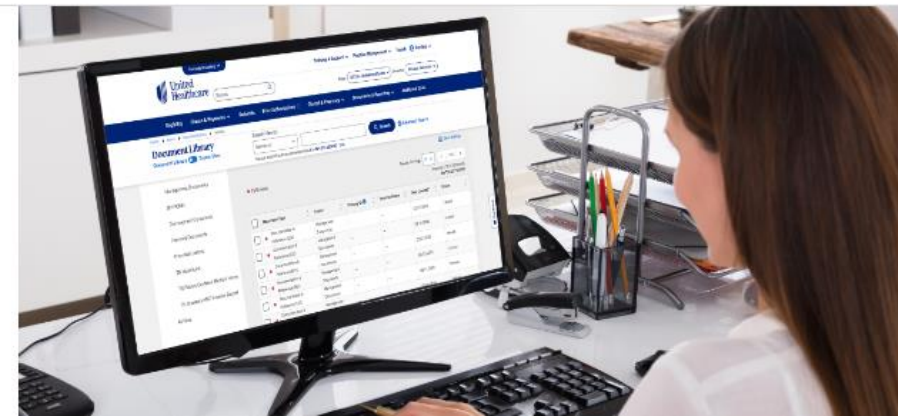


Welcome health care professionals

We invite you to use this website, created especially for health care professionals, to find resources that can help you as you care for your patients. Here you can find our medical policies, stay up to date on the latest news or get training on our many tools and benefit plans. This website is **there for what matters** to health care professionals like you.

Looking for a claim letter?

Forget the mail. Soon Medicare Advantage and commercial plan claim letters must be accessed in Document Library or through an API connection.

[See the details](#)

**Health plans, policies, protocols and guides**

Policies for most plan types, plus protocols, guidelines and credentialing information

Administrative guides and manuals

Specifically for Commercial and Medicare Advantage (MA) products

COVID-19 updates and resources**Drug lists and pharmacy**

Pharmacy resources, tools, and references

Health plans

View health plans available by state

Choose a Location:

Education and training

Updates and getting started with our range of tools and programs

Reports and quality programs

Reports and programs for operational efficiency and member support

Telehealth

Resources and support to prepare for and deliver care by telehealth

News

Important news updates for you

Resource library

Tools, references and guides for supporting your practice

The UnitedHealthcare Provider Portal resources

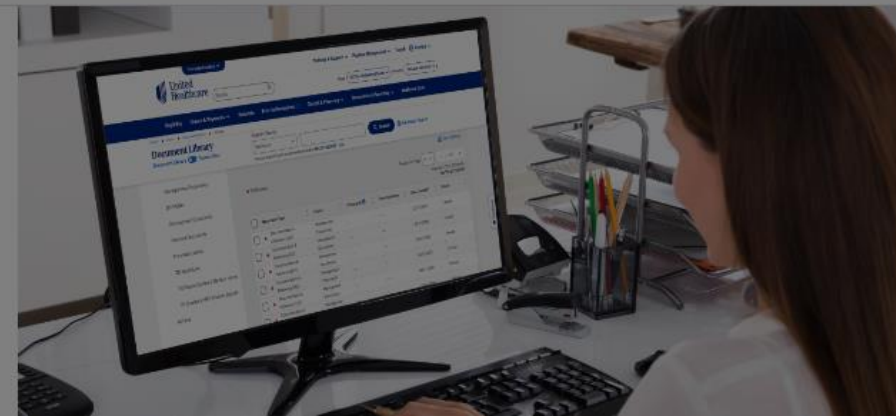
Log in for our suite of tools to assist you in caring for your patients

care professionals

We invite you to use this website, created especially for health care professionals, to find resources that can help you as you care for your patients. Here you can find our medical policies, stay up to date on the latest news or get training on our many tools and benefit plans. This website is **there for what matters** to health care professionals like you.

Looking for a claim letter?

Forget the mail. Soon Medicare Advantage and commercial plan claim letters must be accessed in Document Library or through an API connection.

[See the details](#)

Healthcare Professional Education and Training

We provide a full range of training resources including interactive self-paced courses and instructor-led session. The training content is organized by categories to make it easier to find what you need.

[Digital Solutions](#) [Plans and Products](#) [Clinical Tools](#) [Coding Corner](#) [Smart Edits](#) [State Specific Training](#) [Instructor-Led Learning
Events](#) [Delegated Providers](#) [Veterans Affairs Community
Care Network \(VA CCN\)](#) 

Getting Started with UnitedHealthcare

This is the first course all new care providers should complete. Whether you are new to our network, have a new employee, or simply need a refresher, this self-paced course is designed to give you what you need to get started working with us.

[Register for live training](#) [Start course](#)

Healthcare Professional Education and Training

[Clinical Tools](#)

[Coding Corner](#)

[Delegate Providers](#)

[Digital Solutions Training and Guides](#)

[Instructor-Led Learning Events](#)

[Plans and Products](#)

[Smart Edits](#)

[State Specific Training](#)

[Veterans Affairs Community Care Network \(VA CCN\)](#)

Digital Solutions Training and Guides

Learn how you can save time, get better documentation and reduce paper by using our online self-service tools.



Find what you need fast

When reviewing an interactive self-paced guide, simply click MENU to see all content included. Then, select the topic you need for quick reference. Use the forward arrow to advance to the next page in order or use the HOME icon to switch topics at any time.

Portal Tools

[Collapse All](#) 

Access and Registration

[Access and New User Registration](#)

Easily complete your registration and start using UnitedHealthcare's self-service tools. Our Registration and Access Management guide will walk you through the process step-by-step.

[How to Create and Manage Users](#)

Administrators will see how to create and manage users for the UnitedHealthcare Provider Portal

[3rd Party Access Guide for Primary Access Administrators](#)

Quickly learn how to create and manage users for the UnitedHealthcare Provider Portal using the 3rd Party Access Guide for Primary Access Administrators


Claims Overview

Overview of the features on the UnitedHealthcare Provider Portal for the entire claim process, from the initial submission of a single claim (1500) to checking status and submitting a reconsideration or appeal, if needed and more!

[Register for live event](#) 


Document Library, Paperless Delivery and TrackIt

See how to get letters the day they are generated, access reports, track reconsiderations and pended claims, flag claims for easy access and more.

[Register for live event](#) 


Getting Started with UnitedHealthcare and the Provider Portal

This is the first course all new care providers should complete. Whether you are new to our network, have a new employee, or simply need a refresher, this live event is designed to give you what you need to get started working with us: how to register, verify eligibility and get a member ID card, check prior authorization status, and more.

[Register for live event](#) 

Prior Authorization and Notification

Learn how to check requirements, submit new authorizations / notifications, check status, and submit updates

[Register for live event](#) 

Point of Care Assist

Adding real-time information to improve patient experience and outcomes



How It Works



Real-time members' health data is added to existing Electronic Medical Records for UnitedHealthcare members



Information is delivered as part of providers' current workflow process to ease administration and reduce re-work



Alerts providers to patient care needs, aligned to member-specific benefits



Information is updated in real-time and available 24/7



Prior Authorization By The Numbers:



10,000
Authorization Requests



11 minutes
Time Saved per Request

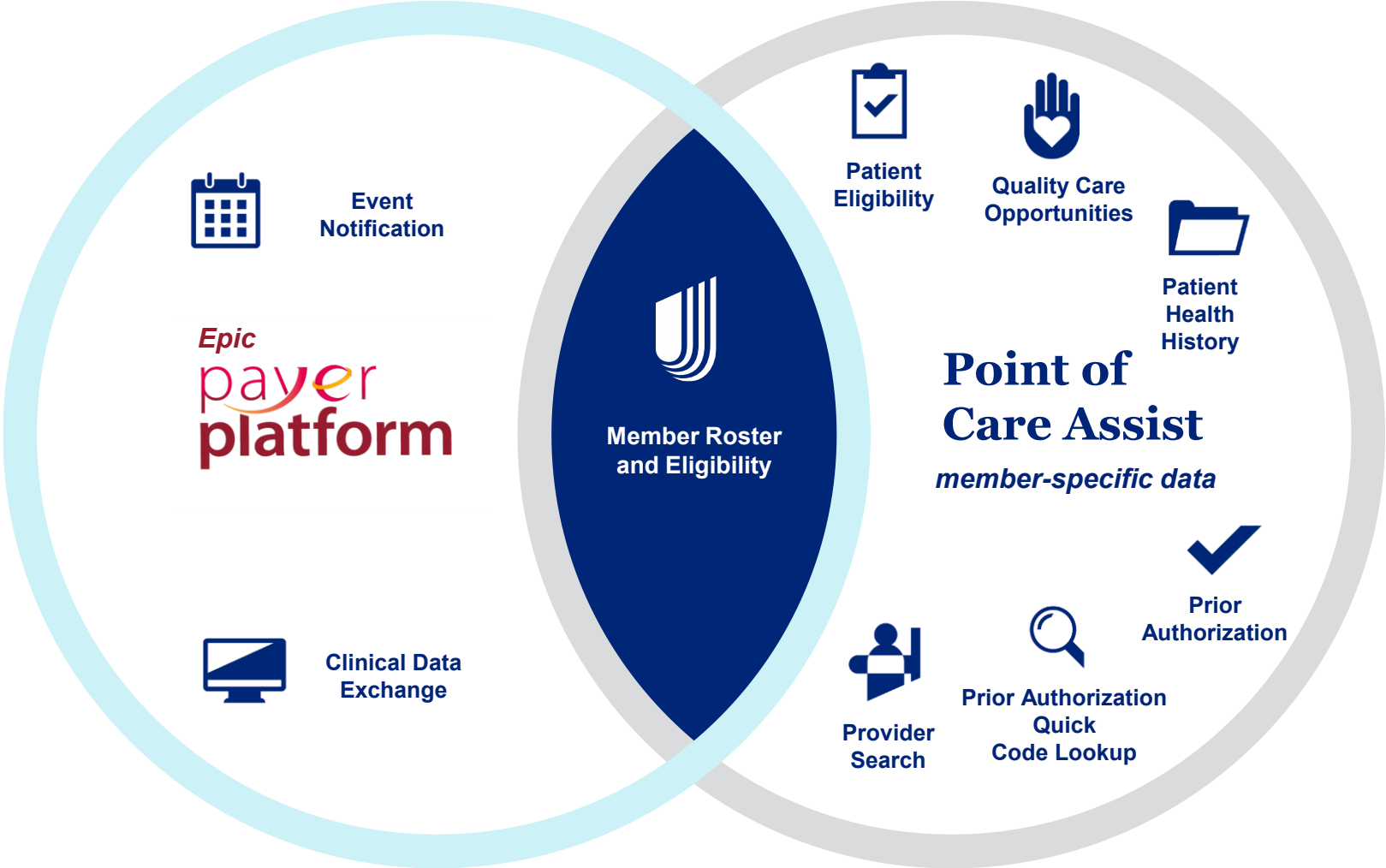


Savings up to \$65,000
and 1,833 staff hours

Total Potential Savings with Point of Care Assist = \$65,000		
Submission Methods	Provider Cost	Time Savings
Fully Manual	\$7.52	16 mins
Partially Electronic	\$6.50	11 mins
Fully Electronic	N/A	N/A



Digital Tools Comparison Example



Point of Care Assist resources

Check out more resources:

- [Point of Care Assist Self-Paced Course](#)
- [Point of Care Assist FAQs](#)

Contact Us

If you have any questions or want to learn more about Point of Care Assist, please e-mail us at POCAnationalteam@uhc.com.





Behavioral Health

Behavioral Health: Determine Prior Authorization Requirements

- Most outpatient behavioral health services do NOT require a prior authorization
- Call the number on the back of the member's card to determine if a prior authorization is required
- Or check online at: [Provider Express - Indiana Medicaid](#)

[Log In](#) | [First-time User](#) | [Global](#) | [Site Map](#)

Optum | Provider Express


Search


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[Optum - Provider Express Home](#) > [Our Network](#) > [State-Specific Provider Information](#) > Welcome Indiana


Welcome Indiana Behavioral Health Providers


Indiana Medicaid Network Participation


 [Indiana Pathways for Aging and Hoosier Care Connect Medicaid Tips](#)


How to submit an Optum participation request 


Credentialing requirements 


Individual Clinician requirements 


Individual clinician step-by-step guides 

Agency requirements 

Facility requirements 

Autism/Applied Behavior Analysis (ABA) 

Submitting additional required information 

Important materials about joining the network 

Provider Communications and General Resources

Prior Authorization and Appeals

Claims

Contacts

Training Resources

Optum network manuals

- [Optum Network Manual](#)
- [UnitedHealthcare Community Plan of Indiana Care Provider Manual -Hoosier Care Connect](#)
- [UnitedHealthcare Community Plan of Indiana Care Provider Manual - Pathways for Aging Provider Manual](#)

Best Practice Guidelines

- [BP Guidelines](#)

InterQual Level of Care Guidelines are used and criteria can be provided upon request for specific cases.

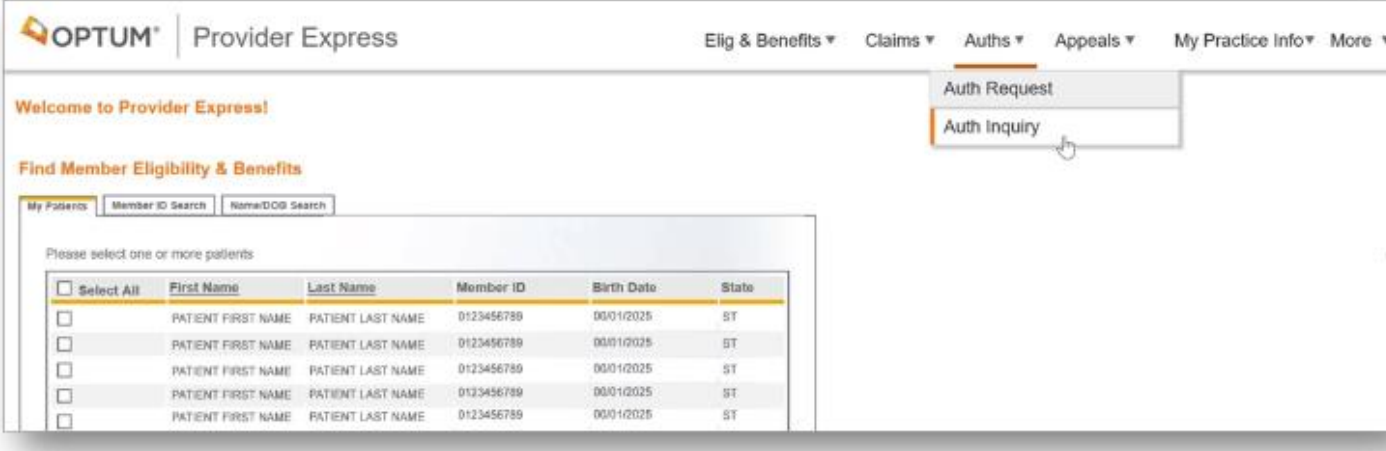
ASAM Level of Care Guidelines are used for Substance Use Disorder (SUD).

Additional information and forms are available, including psych/neuropsych testing guidelines, credentialing plans, and Disability Solutions Manual, on the Provider Express [Guidelines/Policies & Manuals](#) and [Optum Forms](#) pages.



Behavioral Health: Request Prior Authorization

- Securely log-in to Provider Express and select “Auth Request” from the “Auths” dropdown box
- Use the paper Universal Prior Authorization Form from [Indiana Health Coverage Programs Prior Authorization Request Form](#) and click “Prior Authorizations and Appeals”
- Fax to 844-897-6514



OPTUM® Provider Express

Elig & Benefits ▾ Claims ▾ Auths ▾ Appeals ▾ My Practice Info ▾ More ▾

Welcome to Provider Express!

Find Member Eligibility & Benefits






My Patients: Member ID Search Name/DOB Search

Please select one or more patients

<input type="checkbox"/> Select All	First Name	Last Name	Member ID	Birth Date	State
<input type="checkbox"/>	PATIENT FIRST NAME	PATIENT LAST NAME	0123456789	00/01/2025	ST
<input type="checkbox"/>	PATIENT FIRST NAME	PATIENT LAST NAME	0123456789	00/01/2025	ST
<input type="checkbox"/>	PATIENT FIRST NAME	PATIENT LAST NAME	0123456789	00/01/2025	ST
<input type="checkbox"/>	PATIENT FIRST NAME	PATIENT LAST NAME	0123456789	00/01/2025	ST
<input type="checkbox"/>	PATIENT FIRST NAME	PATIENT LAST NAME	0123456789	00/01/2025	ST

▼ Prior Authorization and Appeals

For BH prior authorization, please submit the Universal PA form to 844-897-6514.

- [Universal Prior Authorization Form](#) 
- [Substance Use Disorder \(SUD\) Universal Prior Authorization Form](#) 
- [IHCP SUD Admission Assessment Form](#) 
- [IHCP SUD Reassessment Form](#) 
- [Psych-Neuropsych Prior Authorization Request Form](#) 


For appeals information: uhcprovider.com/Indiana



Behavioral Health: Request Prior Authorization for Applied Behavior Analysis (ABA) Therapy Services

Provider Express – Indiana Medicaid

Step
1

 **OPTUM**[®] Provider Express

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[Optum - Provider Express Home](#) > [Our Network](#) > [State-Specific Provider Information](#) > Welcome Indiana

Welcome to the Optum Network!

Optum Network Manual

- [Network Manual](#)

Best Practice Guidelines

- [BP Guidelines](#)

Autism/Applied Behavior Analysis

- [Indiana Medicaid ABA Program](#)

InterQual Level of Care Guidelines are used and criteria can be provided upon request for specific cases.

ASAM Level of Care Guidelines are used for Substance Use Disorder (SUD).

Additional information and forms are available, including psych/neuropsych testing guidelines, credentialing plans, and Disability Solutions Manual, on the Provider Express [Guidelines/Policies & Manuals](#) and [Optum Forms](#) pages.

Indiana Medicaid-Specific Resources

Provider Communications and General Resources

Claims

Prior Authorization and Appeals

Training Resources

Contacts

Step
2

 **OPTUM**[®] Provider Express

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[Optum - Provider Express Home](#) > [Clinical Resources](#) > [Autism/Applied Behavior Analysis](#) > Indiana Medicaid ABA Program

Indiana Medicaid ABA Program

Optum is excited to announce that **UnitedHealthcare Community Plan of Indiana** has been awarded a contract to service the Indiana. Optum has been selected by UnitedHealthcare Community Plan to develop and manage the ABA network for Indiana network helps to ensure access to comprehensive quality care for covered behavioral health services for enrolled members.

- [Indiana Medicaid ABA Provider Orientation](#) 
- [Indiana Medicaid ABA Quick Reference Guide](#) 
- [ABA Treatment Request Form](#) 
- [ABA Treatment Request Form](#)  (Electronic Submission)

Contact Us/Request to Join the Network

Nacole Thompson
Specialty Network Manager
nacole.thompson@optum.com

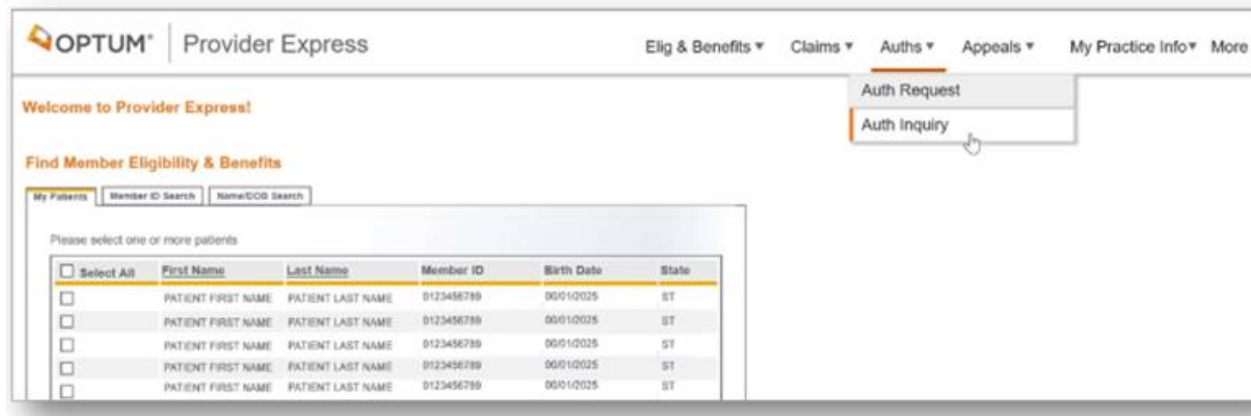




Behavioral Health: Escalate to a Provider Advocate

If provider submits a prior authorization request and does not receive a response within the required turnaround time, do the following:

1. Check the Provider Express portal



2. Call the number on the back of the member's ID card
3. If 1 and 2 do not provide a response, please reach out to your Optum Behavioral Health Advocate



Behavioral Health: Appeal an Authorization Decision

In the event a prior authorization is denied, and an appeal is necessary, make sure to include the following information with the appeal:

- Member name
- Member date of birth
- Member Medicaid ID number
- Denial letter
- Any additional supporting documentation

Send to:

National Appeals Team

Attn: Appeals Department/Retrospective Review

P.O. Box 30512

Salt Lake City, UT 84130-0512

Fax: 855-312-1470

Phone number: 866-556-8166 (8 a.m. to 8 p.m. Eastern, Monday through Friday)





Dental

Dental: Dental Services Requiring Prior Authorization



Prior authorization is required for, but not limited to, the following procedures:

- Endodontics (root canals, root treatments)
- Periodontics (gum tissue treatment)
- Prosthodontics (dentures)
- Oral surgery (bony-impacted extractions, frenectomy)
- Orthodontics (braces)
- Moderate/deep sedation anesthesia



Dental: Determine Dental Service Prior Authorization Requirements

- For a complete listing of procedures requiring prior authorization, refer to the [Dental Provider Manual - UnitedHealthcare Community Plan of Indiana Hoosier Care Connect](#) at uhcdental.com
- When requesting prior authorization, the practitioner must submit planned procedures for approval with clinical documentation supporting necessity before initiating treatment
- For questions concerning prior authorization, dental claim procedures, or to request clinical criteria, please call **Provider Services** at **844-402-9118**
Hours: 8 a.m. to 8 p.m. ET Monday-Friday



Dental: Request Prior Authorization

- Dental providers can submit prior authorization requests online at [SKYGEN DENTAL HUB](#). An account is required. Dental providers can also submit prior authorization requests via mail to the following address:
UnitedHealthcare Dental
Attn: Prior Authorization
P.O. Box 1313
Milwaukee, WI 53201
- The [American Dental Association \(ADA\) Claim Form](#) serves as the prior authorization request. To ensure proper processing be sure to check the box labeled "Request for Predetermination/Preauthorization".



Dental: Prior Authorization Timelines



The following authorization timelines will apply to requests for prior authorization:



UHC will make a determination and provide written notification on *expedited* *authorizations* within 48 hours of receipt of the request.



UHC will make a determination and provide written notification on *standard* *authorizations* within 5 calendar days of receipt of the request.



Authorization approvals will expire 180 calendar days from the date of determination.





Vision

Vision: Prior Authorization



- March Vision Care does not require prior authorization for most routine vision services
- For routine exams, frames, and lenses, please check member eligibility and obtain a benefit confirmation on the [eyeSynergy.com](https://eyesynergy.com) provider portal. An account is required
- For medically necessary contact lenses and fittings, providers need to submit a pricing request form: [Medically-Necessary-Form-Editable.pdf \(marchvisioncare.com\)](https://marchvisioncare.com/Medically-Necessary-Form-Editable.pdf)



Vision: Request a March Vision Care Prior Authorization



- Obtain confirmation by logging in to eyeSynergy.com and searching for the member, verify eligibility and benefits, and generate a confirmation number
- Confirmation number is an 11-digit identification number generated when benefits and eligibility are verified
- Benefits that generally require confirmation numbers include, but are not limited to:
 - Replacement frames and lenses
 - Medically necessary contact lenses for Medicaid members
 - 2 pairs of glasses in lieu of bifocals
 - Prescription sunglasses



Vision: Request a March Vision Care Prior Authorization (cont.)



For medically necessary contact lenses, providers need to submit a pricing request form prior to submitting the claim for reimbursement. Email the completed form with the patient's current eye exam/doctor's notes to providers@marchvisioncare.com.

[Medically-Necessary-Form-Editable.pdf \(marchvisioncare.com\)](#)



Prior Authorization Appeal Process: All Service Lines

- All providers may appeal a prior authorization adverse determination
- An appeal can be filed within 60 calendar days from the date of the adverse determination
- Submitted appeals will be acknowledged within 3 business days
- Please submit your request by mail to:
 - UnitedHealthcare | March Vision Care Attn: Medicaid Vision Appeals P.O. Box 30988 Salt Lake City, UT 84130



Prior Authorization Appeal Process: Outcome

- A decision on the appeal is made within 30 calendar days unless it is expedited
- Expedited appeals are resolved within 48 hours of receiving the appeal and every attempt is made to notify the member orally as well as in writing
- A notification of standard appeal decision is sent within 5 business days of the resolution
- In rare cases, a 14 calendar-day extension may be required. If this is required, both the member and provider are notified
- Appeal notification letters indicate how to file an appeal based on the type of service



Options if the Authorization is Denied

Utilization management (UM)
appeals process

1. Peer-to-peer within 7 (HCC) or 15
(PathWays) calendar days

Call 800-955-7615 8am-8pm ET

2. Next level appeal

3. Fair hearing

Type of request	Decision Turnaround Times	Practitioner notification of approval	Written practitioner/member notification of denial
Non-urgent pre-service	Within 5 business days or 7 calendar days (whichever comes first) of receipt of medical record information required but no longer than 14 calendar days from receipt	Within 24 hours of the decision	Within 2 business days of the decision
Urgent/expedited pre-service	Within 48 hours of request receipt	Within 48 hours of the request	Within 48 hours of the request
Concurrent review	Within 48 hours	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within 2 business days
Retrospective review	Within 30 calendar days of receiving all pertinent clinical information	Within 30 calendar days of determination	Within 30 calendar days of determination; at least 10 business days before the date of action



Medical Network Provider Advocate Team

Provider Account Managers:

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Michelle_b_cole@uhc.com

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Optum Behavioral Health Advocate Team

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Your Dental Advocate Team

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Kristy Jachowske
Provider Advocate
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Kristy_jachowske@uhc.com



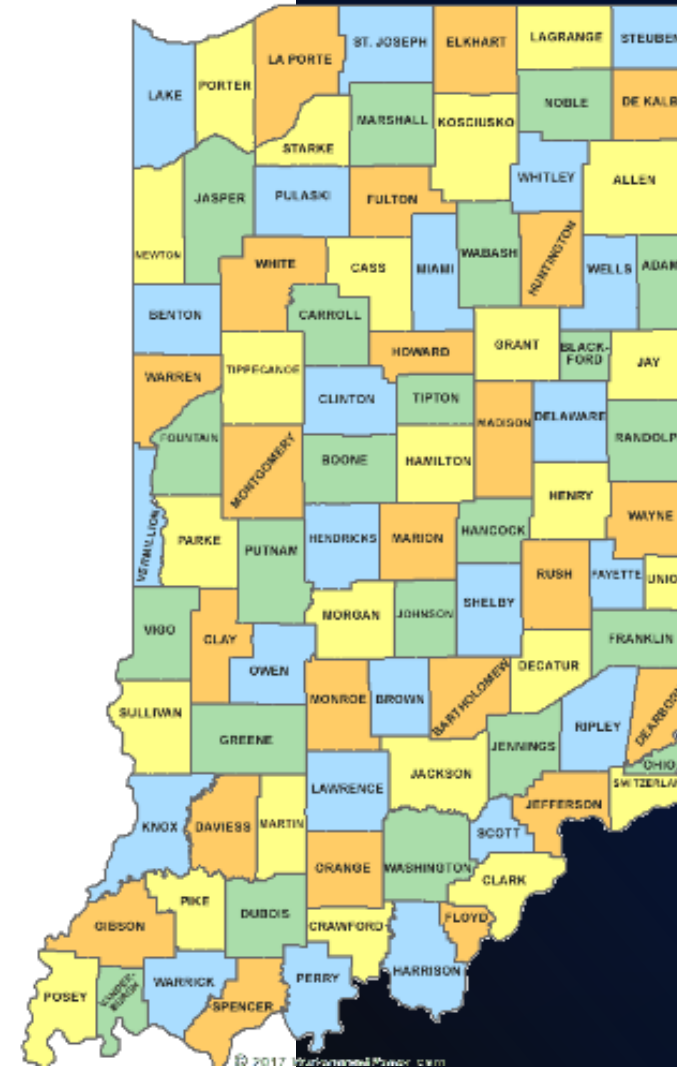
Your March Vision Advocate

Elizabeth Faceson

Sr. Provider Relations Advocate

763-283-2357

efaceson@uhc.com





Appendix

Provider Service Line Website Links

- United Health Community Plan (Medical): uhcprovider.com/INcommunityplan
- UHC Dental: uhcdentalproviders.com
- March Vision Care: marchvisioncare.com
- Optum Behavioral Health: [Provider Express – Indiana Medicaid](#)





Thank you

Questions?

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United
Healthcare